Label

YES	NO	GENERAL HEALTH INFORMATION
		My health is generally good
		Tobacco use? Number of years___ how many a day___
		Vape use? Number of years ___ how many times a day ___
		Alcohol use? How many drinks per week? _____
		Do you use any drugs recreationally? If so, please describe type and frequency of use _____ _____
		Do you use any drugs intravenously (IV) currently or in the past?
		Any history of cancer? If yes where/ when? _____
		Are you being treated for any illness/condition now? If yes, what? _____
		Do you currently take medication? (Prescription, Over the Counter or Herbal) If yes, please list: _____
		Any Allergies to the following? Penicillin Y N Cytotec Y N Doxycycline Y N Latex Y N Lidocaine Y N Epinephrine Y N Codeine Y N Flagyl/ Metronidazole Y N Ibuprofen Y N Methergine Y N Tylenol Y N Aspirin Y N Betadine Y N
		Do you have any known **drug allergies**? If so, please list and describe reaction to medication.
YES	**NO**	**CARDIORESPIRATORY**
		Mitral Valve Prolapse
		Heart Murmur
		Heart Attack
		Blood clots (Lung-Pulmonary Embolism / Head / Legs-DVT)
		Stroke
		High Blood Pressure
		Asthma or other breathing problems
		Tuberculosis
YES	**NO**	**GASTROINTESTINAL**
		Stomach or Bowel problems?
		Liver problems?
		GENITOURINARY
		Bladder or kidney problems
		Uterine fibroids
		Ovarian Cysts
		Vaginal Discharge? If so please describe
		Endometriosis
YES	**NO**	**RHEUMATOLOGICAL**
		Lupus
		Rheumatoid Arthritis

YES	NO	NEUROLOGICAL
		Migraine headaches
		Seizures/ Epilepsy
YES	NO	PSYCHOLOGICAL
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
YES	NO	ENDROCINE
		Thyroid Problems Hypo/Hyper
		Diabetes
YES	NO	HEMATOLOGICAL
		Anemia
		Sickle cell Disease/ Trait
		Bleeding Disorder
		Hospitalization and Surgeries
Year	Reason	
Year	Reason	
		Accidents and Injuries
Year	Reason	
Year	Reason	
YES	NO	GYN HISTORY
		Do you have a bicorniated, septated, or heart shaped uterus?
		Abnormal Pap Test
		Previous Leep, Cone Biopsy or Cryosurgery? If yes, when?
		History of sexually transmitted infection? **When?** _____ **Treated Y or N** Circle type: Herpes Chlamydia Gonorrhea Syphilis Genital Warts Hepatitis: B or C PID HIV
		Regular Periods?
		CONTRACEPTIVE HISTORY
		Method of birth control used in the past year?
		What method do you want to use now?
YES	NO	SOCIAL HISTORY
		Are you currently living in a secure and supportive environment?
		Do you need any information or assistance regarding any type of abuse?
		Has anyone forced you to have sex?
		Are you afraid of your partner?

Any medical conditions not listed above: _____

To the best of my knowledge, the information I have provided is correct and complete. I have received my aftercare instructions.

Patient Signature _____ Date _____

Counseling notes: The above patient is secure with her decision to terminate this pregnancy. She has reviewed all of her options. The procedure & aftercare instructions were discussed. The patient understands possible risks & complications. All of her questions were answered. Patient verbalized understanding of all information.

Counselor Signature_____ Date_____